Connecticut Department of Social Services
Making a Difference

Testimony before the Human Services Committee
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Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am here before you today to testify on bills that impact on the Department.

S.B. No. 409 AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES

The bill requires the department to conduct a study of DSS programs to include: (1) The responsiveness of department programs to recipients of services, (2) identification of problems, if any, that exist within such programs, and (3) whether staff is allocated in a manner to meet the need for services within such programs.

The Department of Social Services supports the basic needs of children, families, elders and older adults, including persons with disabilities, through economic aid, health services, social work services, child support, energy aid, elderly protective services and many others. We currently service more than 750,000 state residents through the several dozen programs administered by the agency.

On July 1, 2013, we launched our statewide ConneCT initiative that seeks to make necessary technological investments as well as transform our antiquated business practices. While we are still rolling out pieces of the project, to date several key components have been implemented and are fully operational, including: one statewide toll-free number, an integrated voice response (IVR) system, three Benefit Centers, "My Account" online feature and the "Am I Eligible" screening tool.

On a typical day, we experience approximately 11,160 people calling the toll-free number and 4,360 use the IVR system. Furthermore, due to a revolutionary business redesign in the way our field offices operate, approximately 85% of people coming into our regional offices are leaving the same day with resolution.

Another key component is the development of a centralized document management center. At the launch of ConneCT, DSS had on hand some 200,000 pieces of unprocessed pieces of paperwork. Today, there are fewer than 3,000.

We are constantly striving to improve our processes. We frequently review our practices and make changes to better serve our consumers. For example, we identified long-term care application processing as an area in need of improvement. In response, we launched four long-term care hubs solely dedicated to processing these applications. In addition, we recently launched an auto-initiation of redetermination so that people do not lose benefits. Through these efforts, we have seen an improvement in the timeliness of processing applications, paperwork is no longer being lost and consumers are able to reach us in person, by phone, and online.

Speaking specifically to this bill, the Department has a number of concerns. First, the scope of the study is not defined. It is unclear if the intent of the bill is for the Department to study all programs administered by the agency, which would be extensive, or if there are specific programs in particular that the report should focus on. This bill also requires the Department to report on "responsiveness of department programs to recipients . . .", however this may be difficult to ascertain. First, the definition of responsiveness is going to differ depending on who is interpreting the language. Second, a follow-up study of this magnitude would most likely have to be contracted out as we do not have the resources to dedicate to this. The Governor's recommended midterm budget, however, does not include any additional funding for such a study. Also, the RFP for consulting services would take a considerable amount of the time allotted to complete a study.

H.B. No. 5500 AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.

This bill proposes several new provisions to be added to the department's statutes, which govern the provider audit process.

The Department has a long history of understanding the need for compliance audits and the value that audits bring to the Medical Assistance programs. The Department also understands that without a financial penalty for non-compliance, the audits would be rendered worthless. The investment in this compliance function has paid dividends. The Connecticut Medicaid program has one of the lowest payment error rates in the United States. The Centers for Medicaid and Medicare Services performs audits the payment accuracy all state Medicaid programs on a three year cycle. The FY 2012 published estimated error rate for Connecticut is 2.2%. This error rate is less than half of the national average and puts Connecticut in the top tier of Medicaid programs.

The primary purpose of our audit division is to assure compliance. For the fiscal year ending June 30, 2103, the Audit Division issued 130 audit reports identifying approximately $20 million in overpayments. The need for compliance in the multi-billion dollar Medicaid program cannot be understated. Connecticut's Medical Assistance Programs are governed by an extensive and comprehensive array of federal and state policies, regulations and statutes. Enrolled providers are entrusted to understand all applicable guidelines and accurately bill for all covered services. Most providers are granted the right to directly bill for goods and services rendered with relatively few upfront edits. It is then our responsibility to ensure both the fiscal and programmatic integrity of these claims. In addition, we believe that there may well be a direct correlation between poor billing compliance and the quality of the related medical services. For

example, a provider cited for inadequate or out of date documentation of care plans may be relying on inadequate or outdated clinical information in making decisions affecting patient care.

It is important to note that proposed Provider Audit Requirements Regulations were developed in collaboration with the Office of the Attorney General and we anticipate that they will be taken up by the Regulations Review Committee at their April meeting. These regulations are a response to Public Act 10-116, which required the department to adopt regulations that would ensure the fairness of the audit process, including, but not limited to, the sampling methodologies associated with the process. The Department believes that any changes to the statute should be postponed to allow implementation of the audit regulations developed pursuant to that directive.

As background, our Quality Assurance provider audit process uses a sample of audit claims and an extrapolation method to determine the number of payment errors and the amount of overpayments to collect from providers. Extrapolation takes the results of a sample and applies it to the larger claims universe. Providers must make repayments to DSS based on these extrapolated error amounts. The Connecticut Supreme Court upheld the use of the extrapolation process in the 2008 Supreme Court ruling *Goldstar Medical Services, Inc. et al. v. Department of Social Services.*

Providers aggrieved by a decision in a final audit report may request a review of the audit findings, which is performed by a designee of the Commissioner outside the Office of Quality Assurance. If a provider is not satisfied with the audit review, the provider may appeal to Superior Court. In addition to this formal review process, providers may request the Director of the Office of Quality Assurance perform an informal review of a final audit report. The Department has the discretion to suspend the recoupment of payments while an appeal is pending.

Specific comments regarding provisions of the bill:

DSS has concerns with the definition of "extrapolation" proposed in this bill. We believe our proposed Provider Audit Requirements regulation defines all necessary terms. Our proposed definitions have been fully vetted through the public hearing process and reflect terminology commonly used in the statistical sciences. In our proposed regulation "Extrapolation" is defined as "...determining an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn." The definition of "extrapolation" proposed in this bill contains ambiguous and undefined terms that would be impossible to administer, such as "nonvalid claim" and "other errors". The Department respectfully requests that if a definition of "extrapolation" is to be established in statute, the definition proposed in our regulation be substituted for the language proposed by the Committee.

Section 1(3) (b) requires the Department to provide Medicaid providers information concerning the audit process, including, but not limited to providing free training for new providers on how to enter claims to avoid clerical errors. Our auditors have conducted numerous training sessions with various provider associations and are committed to continue the outreach to our provider community. Regarding provider billing, the Department's contract with HP requires HP to

provide education about the Medicaid billing process. Education is provided through published "billing manuals" and face-to-face meetings. HP also operates a customer service department to address provider billing questions. If enhancements to the current resources are needed, they can be addressed by DSS without establishing a statutory requirement.

Section 1(3)(c) contains the term "relevant to the audit". Relevance is difficult to define and can be interpreted subjectively. Also, the proposed limitation on what records can be audited is in direct conflict with established regulations. For example, RCSA 17b-262-337, Requirements for Payment of Physicians' Services, includes the requirement:

> *"The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements."*

Additionally, the Provider Enrollment Regulation and the multiple regulations governing provider specialties all contain specific documentation requirements. Most importantly, as the single state agency responsible for administering the Medicaid program, we must assure CMS that our Medicaid claiming is appropriate and consistent with all federal requirements. In order to give this assurance, we must have the ability to review all documents.

The proposed language in Section 1(3) (d) requiring auditors to perform extrapolation of claims based on a sample of like-claims is ambiguous and open to interpretation. The proposed Provider Audit Requirements regulation contains specific language that will avoid inconsistent interpretation. Performing audits on only "like claims" would seem to require the Department to perform multiple audits of each provider in order to establish a statistically valid sample from which to extrapolate. The administrative burden and fiscal impact on the Department would be tremendous and our ability to ensure compliance through the audit process would be compromised as a result. We respectfully request that the proposed Provider Audit Requirements regulations be promulgated and tested over the next few years.

The provision starting on line 33 specifying that DSS should first audit providers with a higher compliance risk could have the unintended consequence of increasing noncompliance across the program because previously compliant providers would know that they would not be audited.

Section 1(3)(e) proposes that DSS not pay on a contingency basis for audit recoveries. This conflicts with requirements under the Affordable Care Act (ACA) that mandate that all states contract with a Recovery Audit Contractor "RAC" to perform audits of Medicaid providers and that they are to be paid on a contingency basis. To meet these ACA requirements, DSS contracts with HMS to perform the RAC audits and pays them a percentage of identified overpayments and underpayments. And let me make clear that only RAC audits are contingency-based. Other audit contracts are not and there are no plans to make them such.

Lastly, the notice requirement contained within this bill is duplicative of current language in CGS section 17b-99 and the proposed audit regulation.

For the reasons stated above the Department is opposed to this bill.